HOSPICE BEREAVEMENT SERVICES PRESENTATION

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I. Introduction and Objectives

A. Participants will be able to name social, spiritual and cultural factors that may impact the ability of bereaved persons to cope with a patient's death.

B. Hospice interdisciplinary members will recognize the importance of ongoing assessments of bereavement risk factors, which must be considered in the plan of care, even prior to the patient's death.

C. Hospice bereavement services staff will have knowledge of the regulatory requirements for Medicare Conditions of Participation and state of Missouri regulations. Bereavement hospice staff will be able to implement and document a bereavement plan of care, which meets not just requirements of regulations, but meets the needs of the bereaved.

II. Federal regulatory requirements for bereavement care and services- found in two Medicare Conditions of Participation (CoP's)

A. Under **CoP 418.54 – Initial and Comprehensive Assessments**: The initial Bereavement assessment -part of the comprehensive assessment that must be completed (in the first five days after the hospice election date) - Hospice team is required to update the comp assesst, including if bereavement risk level changes, during the update to the comprehensive assessment, in the IDG review and documentation (Missouri regulations require an IDG review at least every two weeks).

A(1). **L531 (federal tag) says**: An initial bereavement assessment must be done to include the "needs of the patient's family and other individuals"

- family and other persons who are/ will be bereaved, could include a life-long friend, or a room-mate who has been close to the patient for years. In the initial comprehensive assessment, described in L524, the IDG team should have enough information to know what support systems the patient has (closest family and friends) as well as a beginning understanding of some of the patient's and family history of losses, or other factors that could impact their ability to cope.

A(2). **L531** says: "Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care".

- Some hospices have the initial bereavement assessment in the social worker's initial evaluation document, and some have it incorporated in each of the core services evaluation tools (nursing, spiritual assessment, and social worker). **Caution!** – If you only have the initial bereavement assessment in the social worker's initial psychosocial assessment document, and for some reason the patient refuses the social worker visit, you need to have one of the other team members complete the initial bereavement assessment.

- The guideline to surveyors further clarifies that although a bereavement plan of care is initiated after a death, the hospice must assess and re-evaluate during the ongoing updates to the comprehensive assessment, any new information that could be incorporated into the bereavement plan of care. The guidelines also said: "Bereavement services may be offered **prior** to the death when the initial assessment, comprehensive assessment, or updates to the assessment identifies the need for the patient/ family." IE: what examples can you think of where family or patient need bereavement services prior to the patient's death?

- Examples: a) Patient suddenly lost a grandson in a car accident.

b) Patient and spouse grieving recent news their oldest daughter has end-stage cancer and will be unable to visit the patient/ spouse for some time

3. Guidelines for L531 list some examples of social, spiritual and cultural factors that may impact family or other individual's ability to cope with the patient's death. It says this list includes but "is not limited to":

- history of previous losses

-family problems

- financial concerns

- communication issues (physical or geographic distance?)

-drug or alcohol abuse

-health concerns

-legal/ financial concerns

-mental health issues

-presence or absence of a support system (family/community/ church/ spiritual power the person relies on?)

-feelings of despair, anger, guilt, or abandonment

Most hospices have an initial bereavement assessment document that includes some of these issues, and many others. Not all issues are readily apparent at the initial bereavement assessment. You may find additional issues later, and need to update the bereavement assessment/plan of care. We do not look for a specific list, but that the hospice has a means of identifying bereavement risk factors and updates the risk assessment as changes occur, after the hospice patient is admitted to services.

4. **Finally L531** Guidance to surveyors says we are to look for evidence that the hospice completed an initial bereavement assessment and the "plan of care reflects" or addresses the issues that were found on the assessment.

B. **CoP 418.64: Core Services**, includes physician, nursing, medical social services, and **counseling services (which includes bereavement services) - by hospice's own employees or volunteers—cannot contract for others to do service**

1. **L596** addresses requirement for bereavement services and says it must include:

- Organized program for the provision of bereavement services **under the supervision of a qualified professional** with experience or education in grief or loss counseling (in many hospices this is either a coordinator who has counseling background from IE: CPE training for hospice chaplains, a volunteer who has this special training or lots of experience in a bereavement team, or a social worker who has had the counseling courses for grief and loss).

-Make **bereavement services available to family or "other individuals"** in the bereavement plan of care, including residents of SNF/ NF or ICF/MR facilities (like the room-mates of the hospice patient or a relative of the hospice patient who resides in these facilities), a community member (such as a life-long close friend/ neighbor) and **the bereavement plan of care extends up to one year following the death of the hospice patient.**

- Bereavement **services reflect the needs of the bereaved** (IE: what about multiple family members with different levels of grief coping ability?)—In other words must individualize the plan to the needs and this may mean written plan for more than one individual with differing needs. (IE: What if the bereaved is blind and cannot read the mailed grief info, or is deaf and cannot hear your telephone call or needs a deaf interpreter for conversations? What if the bereaved is a young grandson, age 6?)

- Bereavement plan of care must be developed that notes the kind of "services to be offered and the frequency of services". (Telephone calls weekly, or visit monthly? We surveyors look for a bereavement plan of care that is not just an ongoing checklist of what was done in the past weeks or months, but is a **plan based on needs of bereaved, that gives target dates for what will be done in the future weeks/ months.** Please be sure to document when you are not able to complete the plan of services due to unavailability of the bereaved: IE: the

bereaved refused the visit and asked for no more contacts, the bereaved moved away out-of-state and could only be contacted by telephone, etc. If you have a bereaved individual whose phone number no longer answers and they do not seem to be living at the home address where you used to visit, make sure you contact enough persons that should know where the bereaved might have gone so you can at least get a contact number or forwarding address.

Bereavement services can include: Phone contacts, personal visits, mailed materials, grief counseling sessions (either led by a qualified hospice bereavement counselor, or arranged for by hospice counselor), group grief support sessions, and even email contacts with bereaved who are a long distance from the hospice offices (such as a grandson in the armed services overseas).

A bereavement plan of care is to be individualized, and should consider the individual factors that affect one's ability to cope with the death (including the cultural, spiritual, psychosocial factors that were found during the bereavement risk assessment).

Our state hotline has had several bereavement complaints in recent months. Someone said the hospice sent them a postcard after the death and never called as of one year later. Another said a bereavement counselor called they had never heard of before, and said they would be "willing" to meet them but the counselor made a point of saying they had to "arrange" a time in their schedule and the counselor mentioned they lived and would be driving from quite a distance away (over an hour) so the bereaved said they felt the counselor did not really want to come see them in person, because it would be such an inconvenience. Try to make sure your approach to the bereaved is one that shows you really want to be there for them, and not just your duty, or an option.

C. **Missouri- specific bereavement regulations**: can be found at Code of State Regulations (**19 CSR: 30-35.010) "Hospice Program Operations"**

1. **ML 195** says "within two months following the patient's death, there shall be an assessment of risk of the bereaved individual and a plan of care that extends for one year appropriate to the level of risk assessed."

- From the assessment findings, a level of risk should be assigned. You may decide how you want to score the risk. Many hospices use "Low, Moderate and High" or other scales for bereavement risk.

- Missouri surveyors all interpret this to mean an in-person assessment to the bereaved by two months after the death, and making an individualized plan of bereavement services that would be more involved for a higher bereavement risk score. If the bereaved person refused an in-person visit, we expect hospice would try to offer this again in the future. When the bereaved will not allow an in-person visit, document that the visit occurred on the telephone, information gathered on the phone call, and document all future attempts to make a personal visit. Our surveyors will pick two or three bereavement charts to review at a full Medicare survey. If we see a large percentage of patients who died had no bereavement services because your staff always charts "family refused visits" we will be suspicious there is likely something wrong in your approach. If we have to look at ten charts and see 8 to 10 of these had no personal bereavement services given, no actual visits with the bereaved, we will feel it is very likely you have not made enough efforts to make the services available, or make the bereaved feel you really want to be there for them. We will look for bereavement risk assessments, updates to the assessments and will look for a documented plan of care that shows when and what you planned to do for each bereaved, according to their assessed needs, during the 12 months after the hospice patient's death.

2. **ML 196** says: "In addition to the assessment (referring to the two month assessment), at least one bereavement visit (other than the funeral attendance/visitation) shall occur within six months after the death of the patient." Surveyors do not consider the immediate funeral home visit as meeting the requirement for the assessment (two months) or the six month bereavement visit,

due to being so soon after the death, and in such a public venue. (Consider where the visit could take place to make the individual feel comfortable. It is OK to meet at the hospice office, a private corner of a restaurant, or in a park.)

DISCUSSION OR QUESTIONS:

-How does your hospice approach bereaved individuals to accomplish an in-person assessment at two months and the bereavement visit at six months (Missouri minimum requirement)? Do you offer them anything to encourage them to want to visit with you? (IE: memorial picture or book, or help plant a tree or flower, or special memorial service offered to keep contact?)